Washington State Department of Social & Health Services

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION

ASSISTANCE FOR THIS INDIVIDUAL IS BEING HELD PENDING RECEIPT OF THIS INFORMATION.

A. CLIENT IDENTIFICATION

CLIENT'S NAME	DATE OF BIRTH	CASE NUMBER

Impairment/symptoms claimed by individual

B. AUTHORIZATION TO RELEASE INFORMATION

I authorize _____ to release to the Department of Social and Health Services (DSHS)
EXAMINING PROFESSIONAL'S NAME

the following information regarding my condition, solely to evaluate eligibility for public assistance. This release includes diagnostic testing or treatment information concerning mental health, alcohol or drug abuse, sickle cell disease and the results of sexually transmitted disease, including HIV/AIDS (Revised Code of Washington (RCW) 78.24.105).

INDIVIDUAL'S SIGNATURE	DATE

C. RELEVANT MEDICAL HISTORY

Indicate presenting problems, date of onset, hospitalizations and previous treatment. List alcohol or drug treatment and other medical treatment separately from mental health treatment.

D. CLINICAL FINDINGS

DO NOT COMPLETE THE INTERVIEW IF THE INDIVIDUAL IS INTOXICATED

Please indicate which type of disorder applies to this individual and provide requested information.

☐ 1. **MENTAL RETARDATION:**

a. Provide scores for any Intelligence Quotient (IQ) test you have performed.

Verbal score: _____ Performance score: _____ Full scale score: _____

Date of test: _____ Name of test: _____

b. If test scores are not available, can IQ range be estimated? ☐ Yes ☐ No
Please check range and explain basis for estimation.

85 and above _____ 70 - 84* _____ 69 and below* _____

* Contact the local office for approval for an IQ test before completing this evaluation.

Basis of IQ score estimate for scores of 85 and above:

☐ 2. **ORGANIC MENTAL SYNDROME:** Do not complete this section unless organic mental syndrome is diagnosed under Section E.

		DEGREE OF SEVERITY*				
		NONE	MILD	MOD-ERATE	MARKED	SEVERE
a.	Memory defect for recent events	☐	☐	☐	☐	☐
b.	Impoverished, slowed, perseverative thinking, with confusion or disorientation	☐	☐	☐	☐	☐
c.	Labile, shallow, or coarse affect	☐	☐	☐	☐	☐
d.	Is this condition permanent?	☐	☐	☐	☐	☐

e. Is the present course of this condition:
☐ stable, ☐ deteriorating, ☐ improving, or ☐ unable to determine?

f. Briefly describe evidence upon which these ratings were based:

*** Determining severity f each symptom, based on the degree of the symptom's interference with the individual's ability to perform the basic work-related activities of communicating and understanding and following directions.**

None - No interference.
Mild - No significant interference with basic work-related activities.
Moderate - Significant inference with basic work-related activities.
Marked - Very significant interference with basic work-related activities.
Severe - Inability to perform one or more basic work-related activities.

D. CLINICAL FINDINGS (CONTINUED)

☐ **3.** **FUNCTIONAL MENTAL DISORDER:** Please indicate how this individual could perform during a normal work day, based on objective findings and your professional opinion.

Please use the medial provider instructions, included with this form, to increase reliability of this assessment.

Check only one box when rating the severity of each symptom on the scale.

SHORT CLINICAL RATING SCALE**	DEGREE OF SEVERITY*				
	NONE	MILD	MOD-ERATE	MARKED	SEVERE
a. Depressed mood	☐	☐	☐	☐	☐
b. Suicidal trends	☐	☐	☐	☐	☐
c. Verbal expression of anxiety or fear	☐	☐	☐	☐	☐
d. Expression of anger (verbal and/or physical)	☐	☐	☐	☐	☐
e. Social withdrawal	☐	☐	☐	☐	☐
f. Motor agitation	☐	☐	☐	☐	☐
g. Motor retardation	☐	☐	☐	☐	☐
h. Paranoid behavior	☐	☐	☐	☐	☐
i. Hallucinations	☐	☐	☐	☐	☐
j. Thought disorder	☐	☐	☐	☐	☐
k. Hyperactivity	☐	☐	☐	☐	☐
l. Physical complaints	☐	☐	☐	☐	☐
m. Global illness: Based on intensity and pervasiveness of all symptoms and impairment of functioning. This item is the rater's assessment and is not based only on scores of preceding items	☐	☐	☐	☐	☐

** Archives of General Psychiatry 1970, 23, 233-240, abridged.

E. ASSESSMENT/DIAGNOSIS

1. List each established diagnosis, including the diagnostic code from the diagnostic and Statistical Manual of Mental disorders, Third Edition - Revised (DSM III-R). Include diagnosed alcohol or drug abuse and identify both Axis 1 and Axis 2 diagnosis.

DIAGNOSTIC CODE (DSM III-R)	DIAGNOSIS

2. List each possible diagnosis, where additional information concerning the medial condition must be obtained to either establish or rule out the diagnosis. Please specify the additional information, medical procedures or medical service needed to help define the diagnosis.

POSSIBLE DIAGNOSIS	ADDITIONAL INFORMATION NEEDED

F. SUBSTANCE ABUSE

1. Is there indication of alcohol or drug abuse? ☐ YES; **IF YES, COMPLETION THIS SECTION.** ☐ NO

2. Are any of the diagnosed conditions listed in Section E.1. caused by past or present alcohol or drug abuse? ☐ YES ☐ NO

a. List each diagnosed condition likely caused by alcohol or drug abuse and explain the relationship of the condition to alcohol or drug use.

b. Would alcohol or drug treatment be likely to decrease the severity of the condition?

c. What effect would sixty (60) days of abstinence from alcohol or drug use have on each diagnosed condition likely caused by alcohol or drug use?

F. SUBSTANCE ABUSE (CONTINUED)

3. To what extent does alcohol or drug abuse exacerbate other diagnosed conditions?

4. Does the individual acknowledge the existence of alcohol or drug abuse? ☐ YES ☐ NO
If not, please describe the evidence that indicates alcohol or drug abuse.

G. FUNCTIONAL LIMITATIONS

Please check the degree of limitation that diagnosed conditions impose on the individual's ability to perform on a normal day to day work basis. Basic work-related activities include communicating and understanding and following instructions.

NOTE: Base the degree of limitation on reports by the individual and others concerning behavior over the past month and interpretation of appropriate tests, along with your own observation during the interview.

		DEGREE OF SEVERITY*				
1. Cognitive factors:	NONE	MILD	MOD-ERATE	MARKED	SEVERE
a. Ability to understand, remember and follow simple (one or two step) instructions	☐	☐	☐	☐	☐
b. Ability to understand, remember and follow complex (more than two step) instructions	☐	☐	☐	☐	☐
c. Ability to learn new tasks	☐	☐	☐	☐	☐
d. Ability to exercise judgment and make decisions	☐	☐	☐	☐	☐
e. Ability to perform routine tasks	☐	☐	☐	☐	☐

f. Describe the basis for each rating in this section:

g. Are the above cognitive limitations most likely the result of alcohol or drug abuse?
☐ YES ☐ NO

h. If yes, are the cognitive limitations likely to dissipate within sixty (60) days of sobriety?
☐ YES ☐ NO

2. Social factors:					
a. Ability to relate appropriately to co-workers and supervisors	☐	☐	☐	☐	☐
b. Ability to interact appropriately in public contacts	☐	☐	☐	☐	☐
c. Ability to respond appropriately to and tolerate the pressures and expectations of a normal work setting	☐	☐	☐	☐	☐
d. Ability to care for self, including personal hygiene and appearance	☐	☐	☐	☐	☐
e. Ability to control physical or motor movements and maintain appropriate behavior	☐	☐	☐	☐	☐

f. Describe the basis for each rating in this section:

3. Describe effects of prescribed medication on the individual's ability to perform normal day to day work activities.

4. Describe the effects of the diagnosed conditions on the individual's ability to care for children, if applicable.

H. PLAN OF CARE/PROGNOSIS

	YES	NO
1. Is the individual eligible to receive treatment from your agency?	☐	☐
2. Is mental health intervention likely to restore or substantially improve the individual's ability to work for pay in a regular and predictable manner?	☐	☐

a. Explain:

b. Describe recommended plan of care, including frequency and type of interventions, i.e. medication, psychological rehabilitation, group and individual therapy, day treatment, case management services, etc.

3. Is the individual currently receiving mental health services?	☐	☐
a. Is the individual cooperating with the treatment plan?	☐	☐

b. Explain:

4. Describe treatment results to date.

5. Are additional tests or consultations needed?	☐	☐

Explain (include any recommendations for neurological or physical evaluations not noted elsewhere):

6. Estimate length of time (weeks, months) the individual will be impaired to the degree indicated in Section D (CLINICAL FINDINGS) and Section G (FUNCTIONAL LIMITATIONS).

Maximum _____ Minimum _____

7. Describe conditions which might impair this individual's ability to cooperate with treatment (such as physical handicap, genuine fear of treatment, treatment not reasonably available, religious scruples, difficulty accessing treatment).

I. MENTAL HEALTH PRIORITY POPULATIONS

Does the individual meet the criteria for one of the priority populations defined in the Community Mental Health Services Act (RCW 71.24.035)?

1. ☐ Acutely mentally ill 2. ☐ Chronically mental ill 3. ☐ Seriously disturbed 4. ☐ These terms do not apply

J. ADDITIONAL REMARKS

Other observations which, in our professional opinion, may have a bearing on this individual's ability to perform during a normal work day or to care for children. Please include indication of a possible learning or developmental disability, such as a history of special education, sheltered employment, training, etc.

The information you provide is subject to Washington State Public Disclosure laws and may be released to the individual upon his or her request. all information disclosed from your records will remain confidential under state law and DSHS discloses no further information without the written consent of the individual to whom it pertains, or as otherwise permitted by state law.

Return this report to:

EXAMINING PROFESSIONAL SIGNATURE/TITLE | DATE

PRINT NAME OF EXAMINING PROFESSIONAL | SPECIALTY

ADDRESS STREET

CITY | STATE | ZIP CODE

INCAPACITY SPECIALIST SIGNATURE		EXAMINATION DATE	TELEPHONE NUMBER
TELEPHONE NUMBER	DATE	RELEASING AUTHORITY SIGNATURE/TITLE (FOR USE BY THE VETERANS ADMINISTRATION) OR AREA OF ADVANCED TRAINING FOR ARNP	DATE